

cancer, but such a tool might help to estimate the risk–benefit ratio for her individual case.

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References

1. Wooltorton E. Tamoxifen for breast cancer prevention: safety warning. *CMAJ* 2002;167(4):378-9.
2. Farquhar D. Postmenopausal hormone replacement therapy for chronic disease prevention: results from the Women's Health Initiative trial. *CMAJ* 2002;167(4):377-8.
3. Fisher B, Costantino JP, Wickerham DL, Redmond CK, Kavanah M, Cronin WM, et al. Tamoxifen for prevention of breast cancer: report of the National Surgical Adjuvant Breast and Bowel Project P-1 Study. *J Natl Cancer Inst* 1998;90:1371-88.
4. Gail MH, Costantino JP, Bryant J, Croyle R, Freedman L, Helzlsouer K, et al. Weighing the risks and benefits of tamoxifen treatment for preventing breast cancer. *J Natl Cancer Inst* 1999;91:1829-46.

[Mitchell Gail responds:]

My colleagues and I have shown how to compare the risks and benefits of tamoxifen by combining 3 ingredients:¹ the absolute risks of breast cancer and other endpoints, such as stroke, in the absence of tamoxifen; the effects of tamoxifen on these background risks (from data in Fisher and associates²); and weights for comparing the various outcomes. We used weights of 1.0 for life-threatening outcomes (invasive breast cancer, stroke, pulmonary embolism, hip fracture and endometrial cancer), 0.5 for severe outcomes (in situ breast cancer, deep vein thrombosis) and 0 for other events. We pointed out, however, that a woman's own preferred weights could be used. Tables 10 to 12 in Gail and colleagues¹ indicate that the risks of tamoxifen outweigh the benefits in many women, especially older women in whom the risks from stroke and endometrial cancer are appreciable. Indeed, Rockhill and collaborators³ estimated that only 2.3% of women in the Nurses' Health Study would experience a net benefit, according to Tables 10 and 11 in our study.¹ These observations reinforce the warnings outlined by Eric Wooltorton.⁴

Greiver suggests that the findings of

Gail and colleagues¹ be incorporated into a computer-based tool. Until such a program, properly validated, is available, Tables 10 to 12 in that article provide useful indications of net risk or benefit.¹

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3. Rockhill B, Spiegelman D, Byrne C, Hunter DJ, Colditz GA. Validation of the Gail et al. model of breast cancer risk prediction and implications for chemoprevention. *J Natl Cancer Inst* 2001;93:358-66.
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Getting the word out

In recent correspondence, Greg Allen¹ and Eric Wooltorton² criticized the method that Health Canada used to communicate risks associated with droperidol, in particular the choice of addressees for the drug safety information letter.³ Health Canada sent its letter³ to chiefs of medical staff of all Canadian hospitals, otolaryngologists, retail pharmacies and other health associations. The letter included a request (printed in bold) that it be distributed to health care professionals in each institution, which was an attempt to ensure that the letter would reach all health care professionals who might be prescribing or dispensing injectable droperidol.

Health care professionals have a shared responsibility to acquire, communicate and incorporate new information to enable informed decision-making by patients, and these aspects of professional practice form part of provincial and territorial standards of

professional practice. Nonetheless, concerns about the failure of health care professionals to read "Dear Healthcare Professional" letters and to incorporate new drug safety information into practice have been raised previously.⁴

Health Canada's Marketed Health Products Directorate agrees that physicians and other health care professionals must learn of any new drug safety information quickly. Recommendations arising from a workshop on this topic are posted at Health Canada's Web site.⁵ In addition, several strategies such as toll-free telephone and fax lines for reporting of adverse reactions and an electronic mailing list have been implemented to facilitate communication of product-related risks between Health Canada and health care providers. (Readers may subscribe to various advisory mailing lists at www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/adr.html).

Health Canada hopes that strengthening communication with health care professionals will stimulate spontaneous reporting of adverse reactions. Partnerships with stakeholders such as consumers, health care professionals, academia, industry and government are also important, as the responsibility for communicating drug safety information and incorporating new information into practice crosses jurisdictional lines.

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1. Allen G. Low-dose droperidol [letter]. *CMAJ* 2002;167(5):452.
2. Wooltorton E. Low-dose droperidol [letter]. *CMAJ* 2002;167(5):452.
3. Peterson RG. Cardiovascular toxicity with injectable droperidol. Ottawa: Health Canada, Therapeutic Products Directorate; 2002 Feb 12. Available: www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/advisory/tpd/droperidol_e.html (accessed 2002 Nov 8).
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5. Summary report. Communicating Drug Safety

Information Workshop; 2001 Nov 29-30; Aylmer, QC. Ottawa: Health Canada; updated 2002 Sep 3. Available: www.hc-sc.gc.ca/english/protection/summary_report/index.html (accessed 2002 Nov 8).

A pain in the back

Erica Weir rightly emphasized the importance of a good clinical assessment (history and physical examination) in her recent review of back pain in children.¹ She went on to list potentially helpful investigations and stated that "Testing for rheumatoid factor . . . may be helpful if a rheumatologic disorder is suspected." However, a positive result on such a test would be an extremely nonspecific finding in this setting and would be unlikely to add any useful diagnostic information. The role of laboratory investigations in diagnosing rheumatic disease was reviewed recently in *CMAJ*.²

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Reference

1. Weir E. Avoiding the back-to-school backache. *CMAJ* 2002;167(6):669.
2. Shojania K. Rheumatology: 2. What laboratory tests are needed? *CMAJ* 2000;162(8):1157-63.

Hiphuggers' tingly thighs

Pressure on a sensory nerve can cause pain and paresthesia in the nerve's area of distribution. Entrapment of the median nerve in the carpal tunnel is the commonest example of this problem, but other nerves can be affected. The lateral femoral cutaneous nerve can be compressed as it passes under the inguinal ligament, which results in pain and paresthesia in the lateral aspect of the thigh, a condition commonly known as meralgia paresthetica.¹

I recently saw 3 mildly obese young women between the ages of 22 and 35, who had worn tight "low-rise" trousers (also called hiphuggers) over the previous 6 to 8 months. All presented with symptoms of tingling or a burning sen-

sation on the lateral aspect of the thigh (bilateral in one case). The results of a physical examination were unremarkable, except for mild local tenderness at the anterior superior iliac spine in 2 patients. These 2 patients also had Tinel's sign, whereby a reproducible tingling sensation was elicited when the lateral femoral cutaneous nerve was stimulated by finger-tapping close to the anterior superior iliac spine. One of the women was concerned about multiple sclerosis and requested MRI but was reassured by my explanation of the origin of her symptoms. In all 3 patients, the symptoms resolved after 4 to 6 weeks of avoiding hiphuggers and wearing loose-fitting dresses.

Meralgia paresthetica has been described in association with various garments and accessories (such as wallets² and tight jeans³) causing compression of the lateral femoral cutaneous nerve. Now that hiphuggers are back in fashion, physicians can expect to see more patients with tingly thighs. Simple observation of the patient's mode of dress may give a clue to the diagnosis and prevent unnecessary investigations.

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1. Dyck PJ. The causes, classification, and treatment of peripheral neuropathy. *N Engl J Med* 1982;307:283-6.
2. Orton D. Meralgia paresthetica from a wallet [letter]. *JAMA* 1984;252:3368.
3. Boyce JR. Meralgia paresthetica and tight trousers [letter]. *JAMA* 1984;251:1553.

Corrections

Two errors occurred in the Nov. 26 Public Health piece on syphilis.¹ The surname of the second author, David Fisman, was incorrectly spelled as "Fishman." In Table 1, the major sign for late latent stage syphilis should have read "Asymptomatic \geq 1 yr."

Reference

1. Weir E, Fisman D. Syphilis: Have we dropped the ball? *CMAJ* 2002;167(11):1267-8.

In the Nov. 26 commentary entitled "The editing life,"¹ an error occurred on the third line from the bottom of the article. The due date for submission of applications should read Dec. 16 and not Dec. 31.

Reference

1. Maskalyk J. The editing life [editorial]. *CMAJ* 2002;167(11):1252.

In a recent Pulse column,¹ the x-axis of the figure was mislabelled. The labels Surgical speciality and Lab speciality are reversed. The chart also indicates that 46.3% of physicians from the Class of 1994 chose family medicine. The correct number, 43%, appeared in the text.

Reference

1. Buske L. Class of '94 results point to family medicine's declining popularity. *CMAJ* 2002;167(10):1161.

A recent letter to the editor¹ stated that 2 cardiologists quoted in a medical newsletter used identical comments to describe their conclusions about the same drug. The publisher of the newsletter has informed us that the duplication appeared as a result of a clerical and printing error, which was subsequently corrected on the newsletter's Web site. *CMAJ* has since removed the comments in question from its own Web site.

Reference

1. Brophy J. Medical newsletters: Can they be trusted? [letter]. *CMAJ* 2002;167(9):987.

In the Nov. 26 article on hypertriglyceridemia,¹ an error occurred on page 1264. The fourth sentence under the "Management" heading reads "... follow a low-fat diet (fat intake less than 10% of total dietary energy intake per day)." This should read "... follow a low-fat diet (fat intake less than 10% of total dietary energy intake per day in cases of severe hypertriglyceridemia)."

Reference

1. Fung MA, Frohlich JJ. Common problems in the management of hypertriglyceridemia. *CMAJ* 2002;167(11):1261-6.